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**Department of Personnel and Civil Service**

Room 310 County Office Building

Schoharie, New York 12157-0675

**AUTHORIZATION for DISABILITY RECORD**

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**1. TO BE COMPLETED BY DISABLED VETERAN**

Complete two copies on typewriter, or print in ink. Send both copies to the federal Department of Veterans Affairs office where your disability claim is on file.

**To: Manager, Department of Veterans Affairs, \_\_\_\_\_, New York**

I hereby authorize and request you to furnish the Schoharie County Department of Personnel and Civil Service with the data requested in Section 2, below, pertaining to my disability status. You are released from all liability in complying with this request. It is understood that all information furnished will be treated as confidential.

Veteran's Signature \_\_\_\_\_ Date \_\_\_\_\_

PRINT FULL NAME	VA Claim No.	Service Serial No.
Social Security Number	No. and Title of Exam for which credit is claimed.	
Address		

**2. TO BE COMPLETED BY DEPARTMENT of VETERANS AFFAIRS**

*Please return original to:*

**Department of Personnel and Civil Service, P.O. Box 675, Schoharie, N.Y. 12157-0675**

Date	Claim No.	Regional VA Office
a.	Does the above-named veteran now have a war-incurred disability? [ ] YES [ ] NO If "Yes" please enter date disability was sustained _____, 19____	
b.	Is this veteran receiving disability payments from the V.A. for such disability? [ ] YES [ ] NO	
c.	State percentage of such disability now in existence. %	
d.	Describe the disability.	
e.	Date of last medical examination by the V.A. medical officer in connection with such disability. (IF LESS THAN ONE YEAR AGO, DO NOT ANSWER f and g.) _____, 19____	
f.	Does the V.A. state affirmatively that a permanent stabilized condition of disability exists to an extent of 10% or more, even though claimant has not been examined by V.A. medical officer within one year? [ ] YES [ ] NO	
g.	Date of next scheduled examination by the V.A. _____, 20____	
h.	Remarks	

Signature of Adjudication Officer: \_\_\_\_\_ Date: \_\_\_\_\_, 20\_\_\_\_